

# TARTELL & MANDEL, M.D., LLC

South Florida Sinus and Allergy Center \*\*\* *Head and Neck—Facial Plastic Surgery Associates Of South Florida*

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## Authorization to Discuss Protected Health Information

I, \_\_\_\_\_, authorize \_\_\_\_\_  
to release or discuss information related to my medical condition (including information related to my treatment  
plan, medication information and/or billing information) to the following named persons:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

**PLEASE BE ADVISED THAT ANY PERSON NOT REFERRED TO ON THIS LIST WILL NOT BE  
GIVEN ANY INFORMATION RELATED TO YOUR CARE, INCLUDING BILLING  
INFORMATION. YOU MAY CHANGE, RESTRICT OR EXPAND THIS LISTING AT ANY TIME.**

**YOU ARE NOT REQUIRED TO LIST ANY NAME IF YOU DO NOT SO CHOOSE.**

Please list phone numbers where you would like us to contact you for:

- ◆ Reminder notices
- ◆ Changes on scheduled appointments
- ◆ Messages for the above can be left on an answering machine— Yes,  No

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

Patient name, (Please Print): \_\_\_\_\_

D/O/B: \_\_\_\_\_ S/S#: \_\_\_\_\_

\_\_\_\_\_  
Patient Signature or Legal Guardian